

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO, EASTERN DIVISION

SARAH ARONSON, M.D.	)	CASE NO. 1:08-CV-763
)	
Plaintiff,	)	Judge Christopher A. Boyko
)	
v.	)	DEFENDANT UNIVERSITY HOSPITALS
	)	OF CLEVELAND, INC.'S OBJECTIONS
UNIVERSITY HOSPITALS OF	)	AND ANSWERS TO PLAINTIFF'S FIRST
CLEVELAND, INC.	)	SET OF INTERROGATORIES, REQUESTS
	)	FOR PRODUCTION OF DOCUMENTS,
Defendant.	)	<u>AND REQUESTS FOR ADMISSION</u>

Pursuant to Rules 26, 33, 34, and 36 of the Federal Rules of Civil Procedure, University Hospitals of Cleveland, Inc. ("Defendant" or "UHC"), by and through its undersigned counsel, hereby submits its Objections and Response to Plaintiff's First Set of Interrogatories, Requests for Production of Documents, and Requests for Admission to Defendant.

GENERAL COMMENTS AND OBJECTIONS

Defendant incorporates each of the following comments and objections into each of its answers to Plaintiff's Interrogatories, Requests for Production of Documents, and Requests for Admission. Defendant makes the following responses and objections subject to, and without waiving, any of these comments and objections.

1. Defendant's objections and responses to Plaintiff's Interrogatories, Requests for Production of Documents, and Requests for Admission are based on the information presently available to Defendant, and are made without prejudice to Defendant's right to use subsequently discovered or developed information. Discovery and pretrial preparation may develop further information affecting these responses and objections and Defendant reserves the right to amend and/or supplement its responses and objections accordingly. By these responses, Defendant does

REQUEST FOR ADMISSIONS

1. For each document produced in response to Plaintiff's First Request for Production of Documents, admit that the document is authentic for the purpose of Federal Rule of Evidence 901.

ANSWER: Admit as to all documents prepared by Defendant or its representatives or maintained by Defendant as records of regularly conducted activity as defined in Fed.R.Evid. 803(6). Otherwise, deny.

2. For each document produced in response to Plaintiff's First Request for Production of Documents, admit that the document satisfies Evidence Rule 1003 regarding admissibility of duplicate documents instead of originals.

ANSWER: Admit.



Barton A. Bixenstine
Josephine Noble
127 Public Square, 4130 Key Tower
Cleveland, Ohio 44118
Phone: (216) 241-6100
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Bart.Bixenstine@ogletreedeakins.com
Josephine.Noble@ogletreedeakins.com

*Attorneys for Defendant University Hospitals of
Cleveland*



To: *Florida Board - Mr Knight*
Phone:
Fax: *850-412-1284*

From: *Dr. Nuccio*
Phone:
Fax: 216 844 3781

Date: *1/16/09*

Re: *102050*
cc:

Pages: *2*

Message: *Letter of recommendation for
Dr. David Brown*

Fax

Department of Anesthesiology and
Perioperative Medicine
University Hospitals
Case Medical Center
11100 Euclid Avenue
Cleveland, Ohio 44106
Telephone: 216 844 7340
Fax: 216 844 3781

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January 16, 2009

To Whom It May Concern:


This letter is to serve as a confirmation that Sarah Aronson, M.D. is currently a resident in the Anesthesiology Department at University Hospitals Case Medical Center in Cleveland, Ohio. She is in her CA-3 (or final) year of training.

During her residency she has had no issues of unprofessionalism or misconduct. She has not been suspended, placed on probation or been named in any actions legal or otherwise.

The consensus of the department's Education Committee supports her licensure in your state.

If you have any questions please do not hesitate to contact me.

Sincerely Yours,


Matthew Norcia, M.D.
Vice-Chairman of Education
Residency Co-Director
University Hospitals Case Medical Center

Department of Anesthesiology and Perioperative Medicine
11100 Euclid Avenue Cleveland, Ohio 44106-5077 Phone 216-844-7334 FAX 216-844-3781
University Hospitals Case Medical Center

Printable Form

Page 1 of 6

THE AMERICAN BOARD OF ANESTHESIOLOGY[®], INC4101 Lake Boone Trail, Suite 510 Raleigh, NC 27607-7506
Phone: (919) 881-2570 Fax: (919) 881-2575 Web Site: www.theABA.org

Page: 1 of 4

Resident Name: Sarah Cymry Aronson, M.D.
Resident ABAID#: 3586-2786
Training Period: 2008B
Resident Program: Core Anesthesiology Program #140-015 - University Hospitals of Cleveland

Attached please find a copy of the Clinical Competence Committee Report, which was submitted electronically for the above-named physician. The resident received an overall clinical competence grade of unsatisfactory for the current report period.

The Board requires that the Program Director and/or the clinical competence committee chair and the above-named resident provide acknowledgement that the designated program faculty and the resident have reviewed this important information.

Please note that a resident will have to extend his/her Clinical Anesthesia training beyond 36 months in order to satisfy the requirements of the continuum of education in anesthesiology if:

- ☒ The resident received a CCC Report that is not satisfactory for the most recent period of Clinical Anesthesia training preceding the current report period OR
- ☒ The resident receives a CCC Report that is not satisfactory for Clinical Anesthesia training during the next period of training, OR
- ☒ The resident leaves the program without receiving a satisfactory CCC Report covering the next six months of Clinical Anesthesia training.

The ABA policy regarding creditable CA training is outlined in detail in the Booklet of Information (Section 2.02.C), which is available on the ABA web site at www.theABA.org.

I attest that the Anesthesiology program faculty and/or staff have informed the resident about his/her unsatisfactory Clinical Competence Committee Report, and that the resident has reviewed this information.

 Program Director OR Clinical Competence Committee Chair

 Date

I attest to the fact that the anesthesiology program faculty and/or staff have informed me that my overall clinical competence grade was unsatisfactory for the most recent training period. My signature does not necessarily imply that I agree with the evaluation of my clinical competence.

 Resident Signature

 Date

If you are unable to acquire the resident's signature, please send a brief written explanation providing the reason.

PLEASE RETURN THIS ORIGINAL FORM WITH THE APPROPRIATE SIGNATURES AND DATES TO THE ABA OFFICE BY Jan 31, 2009.

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Page: 2 of 4

Record of Training Report - Previous Training

Resident Name: Sarah Cymry Aronson, M.D.
 Resident ABAID#: 3586-2786
 Training Periods: All periods prior to 2008B
 Resident Program: Core Anesthesiology Program #140-015 - University Hospitals of Cleveland

Previous Training Details

Program	From	To	Type	Grade	Trained	Credit	CCM Trained	CCM Credit
140-015	1/2008	6/2008	Clinical Anesthesia	S	6	6	0	0
140-015	7/2007	12/2007	Clinical Anesthesia	S	6	6	0	0
140-015	1/2007	6/2007	Clinical Anesthesia	S	6	6	0	0
140-015	7/2006	12/2006	Clinical Anesthesia	S	6	6	0	0
140-015	3/2006	6/2006	Clinical Anesthesia	S	4	4	2	2
888-888	1/1988	6/1988	Clinical Base	S	6	6	-	-
888-888	7/1987	12/1987	Clinical Base	S	6	6	-	-

Previous Training Summary

Clin Base	Clin Anes	CCM Mths	Research	Pain Med	Cr Care Med	Peds	Ad Cardio
12	28	2	0	0	0	0	0

Additional Required Training Summary

Clin Base	Clin Anes	CCM Mths	Research	Pain Med	Cr Care Med	Peds	Ad Cardio
0	8	0	0	0	0	0	0

Graduation Summary

Core Estimated	Core Actual	PM Estimated	PM Actual	CCM Estimated	CCM Actual
2/2009	--	--	--	--	--
Peds Estimated	Peds Actual	Cardio Estimated	Cardio Actual		
--	--	--	--		

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Record of Training Report - Current Training

Resident Name: Sarah Cymry Aronson, M.D.
 Resident ABAID #: 3586-2786
 Training Period: 2008B
 Resident Program: Core Anesthesiology Program #140-015 - University Hospitals of Cleveland

Training	Jul	Aug	Sep	Oct	Nov	Dec
Clinical Base						
Clinical Anesthesia	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Research Experience						
Requalification						
Leave Of Absence						
None - Not Enrolled In Program						

Will this Resident Continue Training Next Period?

Yes

Clinical Base Rotations - Clinical Base Training Only!

Rotation type	Months Trained	Rotation type	Months Trained
<input checked="" type="checkbox"/> Anesthesiology	0	<input checked="" type="checkbox"/> Critical Care Medicine	0
<input checked="" type="checkbox"/> Emergency Medicine	0	<input checked="" type="checkbox"/> Family Practice	0
<input checked="" type="checkbox"/> Internal Medicine	0	<input checked="" type="checkbox"/> Neurology	0
<input checked="" type="checkbox"/> Obstetrics/Gynecology	0	<input checked="" type="checkbox"/> Pediatrics	0
<input checked="" type="checkbox"/> Surgery	0	<input checked="" type="checkbox"/> Surgical Specialties	0
<input checked="" type="checkbox"/> Other	0		

Clinical Base Program

Program Name:
 Program City:
 Program State:
 Program Director:
 Program Type:

Clinical Anesthesia Rotations - Clinical Anesthesia Training Only!

Rotation type	Months Trained
<input checked="" type="checkbox"/> Clinical Anesthesia	6

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Resident Name: Sarah Cymry Aronson, M.D.
Resident ABAID#: 3586-2786
Training Period: 2008B
Resident Program: Core Anesthesiology Program #140-015 - University Hospitals of Cleveland

Section 6 - Clinical Competence Report

Clinical competence in anesthesiology, as defined by the American Board of Anesthesiology (ABA), is the initial step toward Board certification in anesthesiology.

The Committee may adopt any form to facilitate the evaluation process; however, the ABA's online report form must be completed by selecting either of two grades:

Satisfactory: Consistently meets reasonable expectations.

Unsatisfactory: Often falls short of reasonable expectations.

Not applicable should be used to denote only those categories not required during the resident's current training rotations.

Evaluation of categories should be relative to that expected for the **current level of training**.

CATEGORIES (As described in the ABA statement "Defining the First Step Toward Board Certification and Maintenance of Certification in Anesthesiology")

Essential Attributes

#	Question	S	U
1	Demonstrates high standards of ethical and moral behavior.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2	Demonstrates honesty, integrity, reliability, and responsibility	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3	Learns from experience; knows limits.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4	Reacts to stressful situations in an appropriate manner.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5	Has no documented abuse of alcohol or illegal use of drugs during this report period.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6	Has no cognitive, physical, sensory or motor impairment that precludes acquiring and processing information in an independent and timely manner.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7	Demonstrates respect for the dignity of patients and colleagues, and sensitivity to a diverse patient population.	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Patient Care

#	Question	S	U	N/A
1	Demonstrates patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Respects patient privacy.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Demonstrates appropriate concern for patients and a commitment to carrying out professional responsibilities.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Is an advocate for quality care.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Demonstrates use of a sound background in general medicine in the management of problems relevant to the specialty of anesthesiology.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Recognizes the adequacy of preoperative preparation of patients for anesthesia and surgery, and recommends appropriate steps when preparation is inadequate.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Selects anesthetic and adjuvant drugs and techniques for rational, appropriate, patient-centered and cost-effective anesthetic management.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Recognizes and responds appropriately to significant changes in the anesthetic course.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9	Provides appropriate post-anesthetic care.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Provides appropriate consultative support for patients who are critically ill.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Evaluates, diagnoses, and selects appropriate therapy for acute and chronic pain disorders.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical Knowledge

#	Question	S	U	N/A
1	Possesses an appropriate fund of medical knowledge.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<https://secure.abanet.org/RTID/CCCPrintPrimary.asp?SSN=36400223&TP=2008B&RECID=91960&Page...> 1/30/2009

UHC001375

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2	Is appropriately self-confident; recognizes gaps in knowledge and expertise.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Demonstrates medical knowledge about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Practice-Based Learning and Improvement

#	Question	S	U	N/A
1	Demonstrates learning and improvement that involves the investigation and evaluation of care for patients, the appraisal and assimilation of scientific evidence and improvements in patient care.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Is committed to practice-based learning and improvement.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Possesses business skills important for effective practice management.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Is complete, accurate and timely in record keeping.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Interpersonal and Communication Skills

#	Question	S	U	N/A
1	Demonstrates effective interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families and other healthcare professionals.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Is adaptable and flexible.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Is careful and thorough.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Professionalism

#	Question	S	U	N/A
1	Demonstrates a commitment to carrying out professional responsibilities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2	Adheres to ethical principles.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Demonstrates sensitivity to a diverse patient population.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Systems-Based Practice

#	Question	S	U	N/A
1	Demonstrates an understanding of the healthcare system and the ability to effectively call on system resources to provide optimal patient care.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Demonstrates an awareness of and responsiveness to the larger context and system of health care.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Clinical Skills

#	Question	S	U	N/A
1	General preparation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	General anesthesia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Regional anesthesia and pain management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Special procedures	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OVERALL CLINICAL COMPETENCE

#	Question	S	U	
1	OVERALL CLINICAL COMPETENCE	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

Section 7 - Explanation

The faculty, through the residency competency committee, has determined that Dr. Aronson's performance does not meet expectations for a resident of her level of training; therefore, for the reporting period of July 1, 2008 through December 31, 2008 she will receive an unsatisfactory evaluation on the Clinical Competence Report to the American Board of Anesthesiology. This decision is based on the following criteria. Under the category of Essential Attributes, the committee has determined that she has been unable to demonstrate the ability to react to stressful situations in an appropriate manner. Under the category of Professionalism, she has failed to carry out her professional responsibility of notifying the Residency Program Directors that she was taking a prescribed medication that could impair her judgment and/or job performance, as required by hospital policy. Additionally, under the category of Patient Care, she has failed to demonstrate her ability to recognize and respond appropriately to significant changes in the anesthetic course.

Approvals

Approved by Program Director: 1/30/2009 4:31:19 PM

Approved by Clinical Competence Committee Chair: 1/30/2009 4:32:37 PM

<https://secure.abanes.org/RTID/CCCPrintPrimary.asp?SSN=36400223&TP=2008B&RECID=91960&Page...> 1/30/2009

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From: Shuck, Jerry
Sent: Monday, June 08, 2009 11:02 AM
To: Nearman, Howard
Cc: Rebello, William
Subject: RE: 6/4/09 mtg

Howard -

This becomes very complicated because: 1) the Board has the recommendation of a six month extension, 2) the clear negative evaluations have come after the decision for extension, 3) any negatives before this were not acted upon, 4) the prior negatives were quite mixed and did not rise to the level of dismissal, 5) each year non-renewal was not utilized if she were so bad, 6) feedback meetings were sporadic before and after the decision, 7) nowhere in her file were any disciplinary actions or letters she reviewed supporting poor performance, 8) at the end of three and a half years you decided she can't finish. This is not the situation you want to be in. Call me.

Jerry

Jerry M. Shuck, MD, D.Sc
Director Graduate Medical Education
Designated Institutional Official
Professor of Surgery
Associate Dean for Graduate Medical Education Case Western Reserve University
University Hospitals of Cleveland 11100 Euclid Avenue Cleveland, OH 44106
216-844-3872 (office)
216-844-1949 (facsimile)

-----Original Message-----

From: Nearman, Howard
Sent: Saturday, June 06, 2009 10:41 AM
To: Shuck, Jerry
Subject: RE: 6/4/09 mtg

Jerry-

In my discussions with Matt and Dave, it does seem like they were never able to "get together" with Sarah in a timely fashion. So she may be accurate in her claims about meetings (or lack of same). Dave is way too emotionally involved in this now to see any view other than his own. While I totally agree that Sarah cannot function independently in a safe manner, I am not absolutely convinced that we have the documentation of giving that information back to her in a timely fashion - as she claims. I am not an expert on the rules/regulations that she cites. What I would suggest at this time is for you to go through what documentation Mat and Dave do have, address Sarah's allegations and advise us on what we should do.
Thanks.

Howard

-----Original Message-----

From: Shuck, Jerry
Sent: Fri 6/5/2009 10:29 AM
To: Nearman, Howard
Subject: FW: 6/4/09 mtg

Howard -

This is getting extremely complicated. This letter was drafted by her lawyer, I'm sure.

9_06_08_Shuck_Email stream_Nearman_RE 6409 mtg_BAD CONTENT re Nearman view that Aronson not competent
Is she accurate?

Jerry

Jerry M. Shuck, MD, D.Sc
Director Graduate Medical Education
Designated Institutional Official
Professor of Surgery
Associate Dean for Graduate Medical Education Case Western Reserve University
University Hospitals of Cleveland 11100 Euclid Avenue Cleveland, OH 44106
216-844-3872 (office)
216-844-1949 (facsimile)

From: Aronson, Sarah
Sent: Friday, June 05, 2009 12:51 AM
To: Shuck, Jerry; Wallace, David; Norcia, Matthew; evasilou@acgme.org
Subject: 6/4/09 mtg






Sarah Aronson, MD
UHHS/Case School of Medicine

Oracle Workflow Notification










From: Patrzyk, Cindy
Sent: Thursday, June 25, 2009 12:45 PM
To: Wallace, David; Norcia, Matthew
Cc: Nearman, Howard; Jezeski, Andrea
Subject: FW: Action Required: Leave Of Absence for Aronson, Sarah with a transaction effective date of 2009-06-25


Attachments: Attachment Info.htm
FYI for scheduling purposes.

From: wfmprod@uhhs.com [mailto:wfmprod@uhhs.com]
Sent: Thursday, June 25, 2009 11:42 AM
To: Patrzyk, Cindy
Subject: Action Required: Leave Of Absence for Aronson, Sarah with a transaction effective date of 2009-06-25

From:  Aronson, Sarah Attachments
To:  Patrzyk, Cynthia
Sent:  25-Jun-2009 11:41:45
Due:  25-Jun-2010 11:41:45
ID:  13947451

Summary

Employee Name  Sarah Aronson 	Employee Number  001040048
Organization Email Address  sarah.aronson@UHhospitals.org 	Business Group  University Hospitals Health System
	 

 Indicates Changed Items.

Absence Details

Proposed

Absence Status Planned
Absence Category Leave - FMLA
Absence Type Leave - FMLA Intermittent
Absence Reason Adoption
Start Date 08-Jul-2009
End Date 15-Aug-2009
Comments and
Supporting anticipate one or two days away required for adoption-related
Information court dates; first is scheduled for July 8 2009.
Employee Phone
Number 216-721-5945

Oracle Workflow Notification

Employee Work

Entity University Hospitals Case Medical Center

Action History

Num	Action Date	Action	From	To	Details
1	25-Jun-2009 11:41:45	Submit	<u>Aronson, Sarah</u>	<u>Patrzyk, Cynthia</u>	see comments above

Related Applications

☐ Update Action

☐ Return For Correction

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Please click on one of the following choices to automatically generate an E-mail response. Before sending the E-mail response to close this notification, ensure all response prompts include a desired response value within quotes.

Action: **Approve** **Reject** **Request Information**

UNIVERSITY HOSPITALS OF CLEVELAND
EMPLOYEE HEALTH SERVICE
MEDICAL HEALTH INVENTORY

U.H. NUMBER:

2686186

NAME:

Hanson Sarah

D.O.B.

ADDRESS:

230 W. 14th St.

CITY/STATE:

Baton Rouge LA

DEPARTMENT:

Infectious Disease

Bldg/Location:

Bldg 210

TITLE:

Fellow

TELEPHONE # (HOME)

(WORK)

844 7335

SOCIAL SECURITY #

1-10223

1. Have you been under a physician's care during the past year for other than routine exams?

YES () NO (X) NAME OF PRIMARY PHYSICIAN

2. ANY HEALTH PROBLEMS IN THE LAST YEAR: PLEASE LIST WITH DATES

Surgical Procedures:

Hospitalizations:

Illness:

Injuries:

INFECTIOUS DISEASE IN THE PAST YEAR	YES	NO	DATE OF ILLNESS
Hepatitis			
Chickenpox			
Tuberculosis/Exposure			

3. DO YOU HAVE THE FOLLOWING CONDITIONS:

High Blood Pressure () (X)
 Heart Disease () (X)
 Seizure Disorder () (X)
 History of Back Problems () (X)

Lung Disease () (X)
 Chronic Cough () (X)
 Diabetes () (X)
 Other _____

List any prescribed medications you are taking:

AMARIL, TORAMAR

Allergies:

4. I have read the education sheet on communicable disease and understand the importance of reporting signs and symptoms of any infectious disease to the Employee Health Service for their review according to established guidelines.

I declare that the foregoing answers are true, correct, and complete to the best of my knowledge.

Please attach documentation of recent skin test. If positive, recent chest x-ray report current within years

(Signature)

(Date)

INFORMATION BELOW COMPLETED BY EMPLOYEE HEALTH SERVICE

Viral Titers Reviewed

Varicella ☒ Immune
 Rubella ☒ Immune
 Rubella ☒ Immune
 Mumps ☒ Immune

Not Immune _____
 Not Immune _____
 Not Immune _____
 Not Immune _____

Immunizations

Hepatitis B Series

HBSAB/AQ

Date of last PPD:

11/8/06

If positive, last chest x-ray:

Date of Exam

EHS Clinical Staff Signature

REV 04/02

UHC001068

UNIVERSITY HOSPITALS OF CLEVELAND
EMPLOYEE HEALTH SERVICE
MEDICAL HEALTH INVENTORY

1/10/62

NAME: SARAH ANSON U.H. NUMBER: _____
 ADDRESS: _____ CITY/STATE: _____
 DEPARTMENT: ANES. BLDG/LOCATION: Buwell 2400 TITLE: MD
 TELEPHONE # (HOME): _____ (WORK) 844 7335 SOCIAL SECURITY # 1-1-0223

1. Have you been under a physician's care during the past year for other than routine exams?

YES (9) NO (11) NAME OF PRIMARY PHYSICIAN Dr. De Joseph

2. ANY HEALTH PROBLEMS IN THE LAST YEAR: PLEASE LIST WITH DATES

Surgical Procedures: Bunionectomy (R foot 3/07)
Illness: _____Hospitalizations: _____
Injuries: _____

INFECTIOUS DISEASE IN THE PAST YEAR	YES	NO	DATE OF ILLNESS
Hepatitis			
Chickenpox		<input checked="" type="checkbox"/>	
Tuberculosis/Exposure		<input checked="" type="checkbox"/>	

3. DO YOU HAVE THE FOLLOWING CONDITIONS:

YES NO
 High Blood Pressure () ☒
 Heart Disease () ☒
 Seizure Disorder () ☒
 History of Back Problems () ☒

YES NO
 Lung Disease () ☒
 Chronic Cough () ☒
 Diabetes () ☒
 Other _____

List any prescribed medications you are taking: Adderall, Topamax, OCP, imitrex or axertAllergies: NKA penicillin

4. I have read the education sheet on communicable disease and understand the importance of reporting signs and symptoms of any infectious disease to the Employee Health Service for their review according to established guidelines.

I declare that the foregoing answers are true, correct, and complete to the best of my knowledge.

Please attach documentation of recent skin test. If positive, recent chest x-ray report current within years

(Signature) [Signature](Date) 11/28/07

Viral Titers Reviewed

Varicella Immune
 Rubella Immune
 Rubella Immune
 Mumps Immune

INFORMATION BELOW COMPLETED BY EMPLOYEE HEALTH SERVICE

Comments
 Not Immune _____
 Not Immune _____
 Not Immune _____
 Not Immune PPV

Immunizations

Hepatitis B: Series: done
HBSAB/AG _____11-29-07

Date of Exam

PPV: 11/29/07
If positive, last chest x-ray: _____[Signature]

ERS Clinical Staff Signature

UNIVERSITY HOSPITALS OF CLEVELAND
EMPLOYEE HEALTH SERVICE
MEDICAL HEALTH INVENTORY

NAME: Aranson Sarah U.H. NUMBER: 2686186
 ADDRESS: _____ CITY/STATE: _____
 DEPARTMENT: _____ BLDG/LOCATION: _____ TITLE: _____
 TELEPHONE #: (HOME) _____ (WORK) _____ SOCIAL SECURITY # _____

1. Have you been under a physician's care during the past year for other than routine exams?

YES () NO () NAME OF PRIMARY PHYSICIAN: Dr. [Signature]

2. ANY HEALTH PROBLEMS IN THE LAST YEAR: PLEASE LIST WITH DATES

Surgical Procedures: _____ Hospitalizations: _____
 Illness: _____ Injuries: _____

INFECTIOUS DISEASE IN THE PAST YEAR	YES	NO	DATE OF ILLNESS
Hepatitis		<u>/</u>	
Chickenpox		<u>/</u>	
Tuberculosis/Exposure		<u>/</u>	

3. DO YOU HAVE THE FOLLOWING CONDITIONS:

	YES	NO		YES	NO
High Blood Pressure	()	()	Lung Disease	()	()
Heart Disease	()	()	Chronic Cough	()	()
Seizure Disorder	()	()	Diabetes	()	()
History of Back Problems	()	()	Other		

List any prescribed medications you are taking: Toradol, Im. [Signature]Allergies: NKA

4. I have read the education sheet on communicable disease and understand the importance of reporting signs and symptoms of any infectious disease to the Employee Health Service for their review according to established guidelines.

I declare that the foregoing answers are true, correct, and complete to the best of my knowledge.

Please attach documentation of recent skin test. If positive, recent chest x-ray report current within year.

[Signature] 11/4/08
 (Signature) (Date)

INFORMATION BELOW COMPLETED BY EMPLOYEE HEALTH SERVICE

Viral Titers Reviewed

Varicella	<u>/</u> Immune	Not Immune	Comments
Rubella	<u>/</u> Immune	Not Immune	
Rubella	<u>/</u> Immune	Not Immune	
Mumps	Immune	Not Immune	

Immunizations

Hepatitis B, Series: 11.4.08 Date of last PPV: 10/1/08
 RBSAB/AQ: 11.4.08 If positive, last chest x-ray: [Signature]
 Date of Exam: _____ EHS Clinical Staff Signature: _____

Corporate Health

University Hospitals
Health System

NEW EMPLOYEE HEALTH QUESTIONNAIRE

Name: SARAH ARONSON Date: 2/24/06
 SSN: 036400723 Job Title: RESIDENT
 Work Location: _____ Department: ANESTHESIA
 Recruiter: _____

	Yes	No
Do you have any medical conditions which would interfere with your ability to perform your job duties? If yes, explain _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever had a work related injury? If yes, explain _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Would any special accommodation be necessary for you to perform your job activities? If yes, explain _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are you on any regular medications? If yes, list <u>LUTERA (O.P) TOPAMAX 75-50 (MIGRAINE) ADDERALL 20 TD (ADHD)</u> <u>IMITREX 100 PRN</u> <u>WELLBUTRIN XL 450 QD</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do you have any special allergies, such as to latex, which would prevent you from performing your job duties? If yes, explain _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Over the last year, have you missed more than 1 week of work because of illness/injury? If yes, explain _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Do you have any other chronic symptom or disorder which would prevent you from performing your job duties? If yes, explain _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Have you ever been a smoker? If yes, are you currently smoking?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Packs per day? _____
 How many years total? _____

CLINICAL STAFF, PLEASE COMPLETE THE FOLLOWING:

Please list dates of the following immunizations, as applicable:

Diphtheria/Tetanus (last dose): Date: 1997

Hepatitis B Date: 1985 Date: 85 Date: 85

MMR Date: AGE 5 OR 6 Date: AGE 5 OR 6

BCG vaccine Date: 8

Varicella Date: AGE 5 OR 6

If you have never had a varicella immunization, have you ever had chickenpox?

Yes ☒ No ☐

Have you ever had a positive TB skin test?

☐ ☒

If yes, give details/treatment etc: _____

I certify that the above statements are true, complete and correct to the best of my knowledge and belief.

Signature: _____

Date: 2/24/06

Reviewed by: _____

Date: 2/24/06**For Corporate Health Use Only**

Blood Pressure

125/78

Heart Rate

85

Assessment:

Attending Psychiatrist → anesthesiology resident.
History of ADHD + migraines. N.P.E.

Plan:

OK pending tox screen.

Comments:

No varicella titer on file - requested lab today.

Reviewer

M. Kelly, MD

Date

2/24/06

Signature _____

HR-14A

Owner: Corporate Health

Revised: December 05, 2005 (Draft #3)

Page 2 of 2

Uncontrolled Document - Printed version only reliable for 24 hours

UHC001072



Hi, ms. | Logout

Update your
account
informationVisit the
Savings
CenterYou have 7
new
messages

Search

Go

CWRU

Care Women Referred University

Home	Prescriptions & Coverage	Health Resources	Customer Care	About Caremark	For Clients	For Health Professionals
------	--------------------------	------------------	---------------	----------------	-------------	--------------------------

My Prescriptions

- Refill Prescriptions
- Check Order Status
- View Prescription History
- New Prescriptions
- Savings Center

My Coverage

- Check Drug Cost
- Find Local Pharmacy
- My Drug List
- My Prescription Plan
- Print Forms

My Account

- Update Profile
- Add Family Members
- Access Mailbox

Contact Caremark**WEB SITE PRIVACY POLICY**Home: [Prescriptions and Coverage](#): [My Prescriptions](#): [View Prescription History](#)**View Prescription History**

Review all of your prescriptions ordered or bought with Caremark, including phone orders, retail purchases, reimbursements, and mail orders. If you need a printable record of all of your past prescriptions on one page, you can get a

Prescription ReportView Prescription(s) for

Prescriptions shown for SARAH ARONSON - 01-10-1962

Show prescriptions for STANLEY AYRES-ARONSO - 09-24-2002

Show prescriptions for SOFIA AYRES-ARONSO - 03-17-2001

Show prescriptions

Prescription Information as of 02/22/2006

Prescriptions listed are for SARAH ARONSON - 01-10-1962

[Previous 10](#) | [Next 10](#)

Rx Number	Drug	Pharmacy	Status	Last Filled
0446229	Wellbutrin XL, 150MG, Brand w/o Generic	RITE AID PHARMACY 2665	Accepted	11/18/2005
5636800	Adderall, 20MG, Brand with Generic	CAREMARK	Accepted	11/09/2005
5636800	Amphetamine Salt Combo, 20MG, Generic	CAREMARK	Accepted	11/09/2005
5636800	Adderall, 20MG, Brand with Generic	CAREMARK	Accepted	11/09/2005
Rx 3606569	Maxalt MLT, 10MG, Brand w/o Generic	CAREMARK	Accepted	11/09/2005
4089978	Lutera, 0.1-0.02, Generic	CAREMARK	Accepted	10/25/2005

UHC001073

THE OCCUPATIONAL HEALTH CENTER

1202 State Street Erie, PA 16501

Provider Physical Form

Today's Date: _____

Patient Name: _____

Birthdate: _____

Heart: ☒ Normal

Rate _____

Rhythm _____

Murmur _____

Back: ☒ NormalCurvature normalMobility goodTenderness 0Scars 0ROM suppl

SLR _____

Spasms _____

Rectal: ☒ NormalDeferred

Masses _____

Hemorrhoids _____

Heme Test Stool _____

Prostate _____

Breasts: ☒ Normal

Self-breast _____

Mastectomy _____

Nodules _____

DeferredSkin: ☒ NormalScars RT knee from old MUI

Tattoo _____

Texture _____

Nails _____

Neurological: ☒ Normal

Reflex/Strength

Biceps _____

Triceps _____

Patella OKRhomberg 0

Sensory _____

Cranial _____

Coordination _____

Abdomen: ☒ NormalContour OKTenderness 0Organomegaly 0Masses 0Striae 0Hernia 0Sounds OKScars 0Genitals: ☒ NormalDeferred

Varicocele _____

Spermatocle _____

Hernia _____

Extremities: ☒ Normal

Strength/ROM

Upper SKLower SK

Edema _____

Varicosities _____

Employee/Person medically qualified to wear:

☐ Respirator☐ Protective Equipment☐ Other☒ No communicable symptoms of communicable disease in an infectious state☒ Able to perform essential functions of this position without accommodation☐ Able to perform essential functions with the following accommodation(s): _____☐ Restrictions / Limitations: _____☐ Follow-up by medical physician recommended.

THE OCCUPATIONAL HEALTH CENTRE

(1202 State Street Erie, PA 16501

Provider Physical Form

Today's Date: 8/26/98

Patient Name: SARAH ARONSON

Birthdate: 1/10/62

Employer: HAMOT

Job Title: Physician

Type of Exam (circle one): Pre-Placement RTW Exit Surveillance Annual Other:

Vision (circle one): Corrected / Uncorrected

Far: O.D. 20/20 O.S. 20/20 O.U. 20/16 Peripheral >70 R L
 Near: O.D. 20/16 O.S. 20/16 O.U. 20/16 Glasses Worn? Yes No

Color Vision (circle one): Ishihara / Yarn / Other Normal Abnormal Impaired but able to distinguish primary colors

Hearing: Whispered Voice Audioscope dB 25/40 Audiogram (see attached)

Frequency (circle one): Right: 500 1000 2000 4000
 Left: 500 1000 2000 4000

Vital Signs: Ht: 67 1/2" Wt: 167 TPR: 98.2 64-16 BP: 124/82 LMP: current

C Dip: Specific Gravity 1.015 pH 5 Albumin 0 Blood trace Sugar 0 On Menses? Yes No

PHYSICAL EXAMINATION

Check if Normal - Explain on lines below if Abnormal

General: Normal

Head: Normal

Eyes: Normal

Posture good

Hair

Lids

Gait steady

Masses

Sclera white

Speech

Tenderness

Conjunctiva pink

Appearance

Muscles

Pupils

Light

Ears: Normal

Mouth/Throat: Normal

Lips

Neck: Normal

Ca

Tongue

Thyroid

Canal

Pharynx pink

Nodes

TM blue

Tonsils

ROM supply

Cerumen Impaction

Teeth

Dentures

Caries

Nose: Normal

Mucosa

Lungs: Normal

Septum

Chest clear

Mucosa

Rubs

Obstruction

Wheezes

Rales/Rhonchi

Provider physical form

02/12/98

UHC001075

PLEASE NOTE: IF YOU ARE TAKING A MEDICATION OR HAVE A MEDICAL CONDITION WHICH CAUSES YOU TO BE IMMUNOCOMPROMISED, YOU ARE AT GREATER RISK FOR ACQUIRING TB. VOLUNTARY WORK REASSIGNMENT MAY BE AVAILABLE TO YOU. PLEASE CONTACT THE EMPLOYEE HEALTH NURSE.

TUBERCULOSIS TESTING AND MONITORING
(SEE REVERSE FOR THOSE WITH HISTORY OF POSITIVE PPD OR TB)

PPD TEST CONSENT

CONSENT

DATE 3/17/99 DEPT FP UNIT
NAME SARAH ARONSON SS# 036400223
PRINT

TO MY KNOWLEDGE, I HAVE NEVER HAD A POSITIVE PPD TEST OR ACTIVE TB.

SIGNATURE [Signature]

TO BE COMPLETED BY EHS/DESIGNEE:

PLACEMENT

History of BCG	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Initial Placement	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Second Step of 2-Step	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Annual Testing	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Semi Annual Testing	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Date 3/17/99 Site Bureau MFG & Lot # 2498-1 Signature Barb Kuchman LPN
3/2/00

DATE TO BE READ BY 3/19/99

RESULTS imm in injection Date Interpreted 3/19/99

Read By [Signature]
Signature

RESULTS

WHEN COMPLETED PLEASE RETURN TO EMPLOYEE HEALTH SERVICES

Follow-Up Recommended

Referral Made To:

FOLLOW-UP

A:2/97

MANDATORY OSHA INFORMATION

DATE 8/27/98

NAME ARONSON, SARAH, C. MD
DOB: 1/10/62 AGE: 36
SS# 036-400-223
Physician

DOB 1/10/62

SS# _____ DEPT _____

HEPATITIS B VACCINE STATUS

☒ I HAVE COMPLETED THE VACCINE SERIES. DATE 1987

☐ I AM IN THE PROCESS OF RECEIVING THE VACCINE SERIES.

☐ I AM INTERESTED IN RECEIVING THE VACCINE.

☐ I AM NOT INTERESTED IN RECEIVING THE VACCINE.

SIGNATURE

7/94

PLEASE NOTE: IF YOU ARE TAKING A MEDICATION OR HAVE A MEDICAL CONDITION WHICH CAUSES YOU TO BE IMMUNOCOMPROMISED, YOU ARE AT GREATER RISK FOR ACQUIRING TB. VOLUNTARY WORK REASSIGNMENT MAY BE AVAILABLE TO YOU. PLEASE CONTACT THE EMPLOYEE HEALTH NURSE.

TUBERCULOSIS TESTING AND MONITORING
(SEE REVERSE FOR THOSE WITH HISTORY OF POSITIVE PPD OR TB)

PPD TEST CONSENT

CONSENT

DATE 3/8/00 DEPT FAM MED UNIT _____
NAME Aranson, Sarah SS# 026400223
PRINT

TO MY KNOWLEDGE, I HAVE NEVER HAD A POSITIVE PPD TEST OR ACTIVE TB.

SIGNATURE [Signature]

TO BE COMPLETED BY EHS/DESIGNEE:

PLACEMENT

History of BCG	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Initial Placement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Second Step of 2-Step	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Annual Testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Semi Annual Testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Date 3/8/00 Site Offices MFG & Lot # PMC 0014AA Signature Sandra K Tate, RN
2/8/01

DATE TO BE READ BY 3/10/00

RESULTS Immune to TB Date Interpreted 3/10/00

Read By [Signature]
Signature

RESULTS

WHEN COMPLETED PLEASE RETURN TO EMPLOYEE HEALTH SERVICES

Follow-Up Recommended _____

Referral Made To: _____

FOLLOW-UP

A:2/97

**University Hospitals
Health System**

University Hospitals
of Cleveland

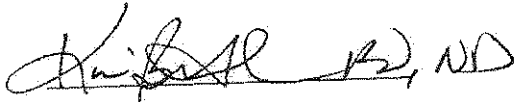
REC'D DEC 05 2003

Ray

To: Tina Burin
Re: Medical Staff Re-credentialing

4 Dec 2003

This is to state that Sarah Aronson's PPD test (placed 12/1/03) is negative.


KIM HUCK, RN MD

PLEASE NOTE: IF YOU ARE TAKING A MEDICATION OR HAVE A MEDICAL CONDITION WHICH CAUSES YOU TO BE IMMUNOCOMPROMISED, YOU ARE AT GREATER RISK FOR ACQUIRING TB. VOLUNTARY WORK REASSIGNMENT MAY BE AVAILABLE TO YOU. PLEASE CONTACT THE EMPLOYEE HEALTH NURSE.

TUBERCULOSIS TESTING AND MONITORING
(SEE REVERSE FOR THOSE WITH HISTORY OF POSITIVE PPD OR TB)

PPD TEST CONSENT

 8/26/98

ARONSON, SARAH, C. MD
DOB: 1/10/62 AGE: 36
SS# 036-400-223
Physician

TO MY KNOWLEDGE I HAVE NEVER HAD A POSITIVE PPD TEST OR ACTIVE TB.

SIGNATURE [Signature]

TO BE COMPLETED BY EHS/DESIGNEE:

History of BCG	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Initial Placement	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Second Step of 2-Step	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Annual Testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Semi Annual Testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Date 8/26/98 Site LTA MFG & Lot # 2465-11 Signature [Signature]
Tubersol (pinaught) exp 2/99

DATE TO BE READ BY

RESULTS [Signature] **Date Interpreted** 8/28/98

Read By [Signature]
Signature

WHEN COMPLETED PLEASE RETURN TO EMPLOYEE HEALTH SERVICES

Follow-Up Recommended Had placed previously 1998

Referral Made To:

HAMOT HEALTH FOUNDATION

EMPLOYEE HEALTH SERVICES

NAME: ARONSON, SARAH, C. MD
 SS#: DOB: 1/10/62 AGE: 36
 SS# 036-400-223
 DOB: Physician

from recd.

(Signature)

HEALTH QUESTIONNAIRE : no ☒ yes Date 8/25/98

DISEASE	HISTORY	Date	Date	Date	Date	Comments
Chickenpox required	Verbal History: <input checked="" type="checkbox"/> Titer results: Vaccine dates:	8/25/98				
Rubella required	Titer results: <i>7.2 Immune</i> Vaccine dates: <i>8/25/98</i>					
Rubeola required	Titer results: <i>1.86 Immune</i> Vaccine dates: <i>8/25/98</i>					
TB Screening required, annual required unless dept is exempted	Mantoux PPD: If positive, follow-up documentation: Annual questionnaire	<i>8/25/98</i> <input checked="" type="checkbox"/>				
Tetanus/Diphtheria	Date of last booster	1997				
Hepatitis B Vaccine if at risk for occupational exposure to BBP	Completed: <input checked="" type="checkbox"/> Post vac titer: <input checked="" type="checkbox"/> or Consent: Refusal:	1987 <input checked="" type="checkbox"/>				

reviewchart2-98

OTHER AREAS TO REVIEW:

WORKER'S COMPENSATION ACKNOWLEDGEMENT ☒ yes no

Reviewer initials *bes*

Date 8/31/98

27-Feb-2006

Clinical Reference Laboratory

08:19

CLIA #17D0667123 SAMHSA #0007 CAP #30211-01

UNIVERSITY HOSP HLTH SYST NAME: ARONSON, SARAH SAMPLE ID: 76092450
 NANCY DALE DOB: N/S COLLECTED: 02/24/06
 11100 EUCLID AVE SSN: NS RECEIVED: 02/25/06
 ROBB HOUSE MAIL STOP 6029 GENDER: N/S REPORTED: 02/27/06
 CLEVELAND, OH 44106 SLIP ID: 0047608391 FAX: (216) 844-3990
 PH: (216) 844-4830 REF ID: NS
 COLL. SITE ID: UHHUHC REFERENCE 1: NONDOT DEFAULT
 REFERENCE 2:

SITE ADDR: UNIVERSITY HOSP HLTH SYST SITE BRANCH: UNIVERSITY HOSP-CLEVELAND
 11100 EUCLID AVE SITE PHONE: (216) 844-4830
 ROBB HOUSE STOP 6029 SITE FAX: (216) 844-3990
 CLEVELAND, OH 44106

REASON FOR TESTING: PRE-EMPLOYMENT
 SAMPLE TYPE: DRUG SCREEN (9 PANEL)

URINALYSIS	RESULT / STATUS	CUTOFF/EXPECTED VALUES
URN CREATININE	162.2	20.0-300.0 mg%

INITIAL TEST	RESULT / STATUS	CUTOFF VALUE
COCAINE METABOLITES	..... NEGATIVE	300 ng/mL
AMPHETAMINES (CLASS)	..... POSITIVE	1000 ng/mL
BARBITURATES	..... NEGATIVE	300 ng/mL
BENZODIAZEPINES	..... NEGATIVE	300 ng/mL
MARIJUANA METABOLITE	..... NEGATIVE	50 ng/mL
OPIATES	..... NEGATIVE	300 ng/mL
PHENCYCLIDINE	..... NEGATIVE	25 ng/mL
PROPOXYPHENE/METABOLITE	..... NEGATIVE	300 ng/mL
METHADONE	..... NEGATIVE	300 ng/mL

CONFIRMATION	RESULT / STATUS	CUTOFF VALUE
GC/MS AMPHETAMINE	>10000 POSITIVE	500 ng/mL

*OK by history
MK 2/28/06*

LAB DIRECTOR: RANDAL E. CLOUETTE, MSFS, RP

CERTIFIED BY MARTY C. ECKSTEIN

Page 1

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 8433 Quivira Road. Lenexa, Kansas 66215. (913) 492-3652

PCB: CLS.UHH.UHC.DEFNON

[end of report]

UHC001085

ACL

a QUEST Diagnostic, Inc. Affiliate

CLINICAL LABORATORY REPORT

1526 PEACH STREET

ERIE, PA 16501

Antonio I. Garman, M.D.
Antonio I. Garman, M.D.
Medical Director

Patient Name	Client Services Helpline	Billing Helpline	Date Collected	Time Collected
ARONSON, SARAH	(814) 461-2400	(814) 461-2430	08/26/98	15:45
Patient Phone Number	410066 19-99-099		Date Received	Date of Report
	HAMOT EMPLOYEE HEALTH SERVICES		08/26/98	08/30/1998
Patient I.D./Social Security Number	201 STATE ST		Sex	Age
036-40-0223	ERIE, PA 16507		F	36
Referring Physician			Specimen Number	Accession Number
FERRIS, JOSEPH M. D.				EA219484A

TEST PROCEDURE	TEST RESULT	UNITS	REFERENCE RANGE
HEPATITIS B SURFACE ANTIBODY	POSITIVE*		NEGATIVE A
RUBELLA ANTIBODY IGG	79.2 ✓	IU/ML	A

REFERENCE RANGE (RUBELLA AB IGG):

< 5 IU/ML	PRESUMED NON-IMMUNE
5 TO <10 IU/ML	EQUIVOCAL
10 IU/ML OR GREATER	PRESUMED IMMUNE

ANTIBODY LEVELS IN THE EQUIVOCAL RANGE MAY BE INSUFFICIENT TO PROTECT AGAINST CLINICAL ILLNESS UPON EXPOSURE TO RUBELLA VIRUS.

ANTIBODY LEVELS GREATER THAN OR EQUAL TO 10 IU/ML ARE POSITIVE FOR IGG ANTIBODY TO RUBELLA VIRUS AND INDICATE ACUTE OR PAST INFECTION.

RUBELLA ANTIBODY IGG, ELISA

1.86

ISR

P

ISR

INTERPRETATION OF RESULTS

LESS THAN 0.91

NEGATIVE FOR ANTIBODIES TO RUBELLA IGG.

0.91 - 1.09

EQUIVOCAL*

GREATER THAN OR EQUAL TO 1.10

POSITIVE

*EQUIVOCAL RESULT SUGGESTS PATIENT SHOULD BE RETESTED IN 5 TO 7 DAYS.

IF RETESTED RESULT IS STILL EQUIVOCAL, THE PATIENT HAS NO SIGNIFICANT ANTIBODIES TO RUBELLA IGG.

REFERENCE RANGES PROVIDED BY ASSOCIATED CLINICAL LABS. PERFORMING SITES ARE ADULT/NON-SEX SPECIFIC UNLESS

@ = AGE RELATED; @@ = SEX RELATED; @@@ = AGE & SEX RELATED PRINTED

ACL

a QUEST Diagnostic, Inc. Affiliate

CLINICAL LABORATORY REPORT

1526 PEACH STREET

ERIE, PA 16501


 Antonio I German, M.D.
 Medical Director

Patient Name

ARONSON, SARAH

Client Services Helpline

(814) 461-2400

Billing Helpline

(814) 461-2430

Date Collected

08/26/98

Time Collected

15:45

Patient Phone Number

Patient I.D./Social Security Number

036-40-0223

Referring Physician

FERRIS, JOSEPH M. D.

410066 19-99-079

 HAMDT EMPLOYEE HEALTH SERVICES
 201 STATE ST
 ERIE, PA 16507

Date Received

08/26/98

Date of Report

08/30/1998

Sex

F

Age

36

ID Number

Specimen Number

Accession Number

EA219484A

TEST PROCEDURE

TEST RESULT

UNITS

REFERENCE RANGE

PERFORMING SITE CODE BREAKDOWN

CODE

PERFORMING SITE

ADDRESS

=====

=====

=====

A

ASSOCIATED CLINICAL LABS

ERIE, PA

P

QUEST DIAGNOSTICS INC.

875 GREENTREE RD., PCH. PA

ARONSON, SARAH

CONSOLIDATED FINAL REPORT 1

HAMDT EMPLOYEE HEALTH SER *NOTE: SOME OR ALL RESULTS WERE PREVIOUSLY REPORTED.

UHC001087

03/03/08 03:12 PM EST Univ Hosp Health Sys via VSI-FAX Page 2 of 18 #1510

University Hospitals
Laboratory Services
11100 Euclid Avenue * Cleveland, OH 44106-5199
(216)844-5227 * FAX (216)844-7580

REQUESTED BY: ROSENBERG, DAVID
ATT. PHYSICIAN: ROSENBERG, DAVID
ADDT'L COPY TO:

ARONSON, SARAH MD
BIRTHDATE SEX: 01/10/1962 F
PATIENT #: 02686186
ORDERED: 03/01/08 11:44
ROOM# BED:

FINAL

TEST NAME	RESULTS	REF VALUES	UNITS	TS	DATE
-----------	---------	------------	-------	----	------

SEROLOGY

COLLECTED 03/01/08 11:30

VARICELLA ZOSTER ANTIBODIES

VARICELLA ZOSTER IGG AB 3.88

C

	INDEX	UH	03/03/08 14:59
NON-IMMUNE:	<0.75		
EQUIVOCAL:	0.75 - 0.99		
IMMUNE:	>1.00		

RESULTS WERE OBTAINED WITH THE DIAMEDIX
VZV IGG EIA TEST SYSTEM. THE
MAGNITUDE OF THE REPORTED RESULT CANNOT
BE CORRELATED TO AN ENDPOINT TITER.

C

KEY: L=LOW H=HIGH *ABNORMAL IS=Test Site (see reverse for code interpretation) LAB# F9011938 AUX# L106596

EMPLOYEE HEALTH SERVICES - UHC
11100 EUCLID AVE ROBB HOUSE 3RD FLOOR
CLEVELAND OH 44106